

MDR Tracking Number: M5-05-1252-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12-27-04.

The Respondent submitted payment information for dates of service 11-02-04 and 11-23-04, therefore these dates of service are no longer in dispute and will not be part of the review.

I. DISPUTE

Whether there should be reimbursement for CPT code 99080-73 dates of service 08-09-04 and 08-30-04 and CPT code 99080-69 date of service 09-20-04.

II. FINDINGS

On 01-28-04, an Order For Payment Of Independent Review Organization Fee was issued to the Requestor. The Requestor failed to make payment of the IRO fee as required by Commission Rule 133.308 (r)(1)(B) and subsequently, the medical necessity issues were dismissed. On 01-11-05 per Rule 133.307(g)(3), a Notice was sent to the Requestor requesting the Requestor to submit additional documentation necessary to support the fee charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the Requestor's receipt of the Notice. A Compliance and Practices referral will be made due to the healthcare provider violating Rule 133.308(r)(1).

III. RATIONALE

CPT code 99080-73 dates of service 08-09-04 and 08-30-04 were denied with denial code "V" (unnecessary medical per peer review). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2 DOS)**. A Compliance and Practices referral will be made due the carrier violating Rule 129.5.

Review of CPT code 99080-69 date of service 09-20-04 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement for CPT code 99080-69. The

Division has determined that the requestor **is** entitled to reimbursement for CPT code 99080-73 dates of service 08-09-04 and 08-30-04.

V. ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 08-09-04 and 08-30-04 in this dispute. Total reimbursement is **\$30.00**.

This Order is hereby issued this 17th day of March 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh